WRITTEN COMMENTS

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House Ways and Means Subcommittee on Health
Hearing on "Protecting Patients from Surprise Medical Bills"
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Chairman Doggett and Members of the House Ways and Means Subcommittee on Health, thank you for bringing public attention to "surprise billing," also referred to as "balance billing" – a topic of great concern to many of Adventist HealthCare's patients and their families. Thank you also for the opportunity to submit these written comments for the record.

Adventist HealthCare is a faith-based, not-for-profit organization whose mission is "to extend God's care through the ministry of physical, mental and spiritual healing" throughout the Washington, D.C. region. Founded in 1907, Adventist HealthCare is the first, largest and only health system headquartered in Montgomery County, Maryland. We currently operate two nationally accredited acute-care hospitals, a nationally accredited rehabilitation hospital, mental health services, home health agencies, numerous physician networks, and urgent care centers. In keeping with our not-for-profit mission and community-based values, in 2017 Adventist facilities and programs served the community with approximately 752,000 encounters. Our commitment to community-focused service is exemplified through a variety of programs such as our:

- Community Partnership Fund, which provides funding for organizations whose activities support the health and wellbeing of our community; (https://www.adventisthealthcare.com/about/community/partnership-fund/)
- Center for Health Equity and Wellness which was created to raise community awareness about local health disparities, improve capacity to deliver population-based care and

develop solutions to eliminate local disparities in health care (https://www.adventisthealthcare.com/health/equity-and-wellness/).

It is this strong sense of service that motivated Adventist HealthCare to determine how the patient experience could be improved with regard to billing – not just surprise billing but billing overall. To that end, we commissioned respected health policy experts, Dobson DaVanzo & Associates, to develop a white paper examining the health care billing process and proposing to better serve the patient by realigning the billing and collection of deductibles, coinsurance and copayments.

From the patient perspective, the analysis validated what we already knew: health care billing in general is confusing and frustrating; increased cost sharing and "balance billing" (surprise billing), in particular, cause patients and their families difficulty and stress. Bills for major medical treatments are even more complex and patients rarely have any idea what their out-of-pocket costs will be before a procedure is performed.

At the same time, billing is also difficult for providers. The significant administrative and cost burden of billing is poorly understood and continues to increase as systems and insurance coverage become more complex. A recent study estimated the time and costs for billing and insurance-related activities ranges from **13 minutes/$20.49 for a primary care visit** to **32 minutes/$61.54 for an emergency department visit,** to **73 minutes/124.26 for a general inpatient stay,** to **100 minutes/ $215.10 for an inpatient surgical procedure**."[1]

This all begs the question – why are providers billing insured patients in the first instance? Insurers have the financial relationship with patients and are best able to collect provider invoices (whether in or out of network), negotiate reimbursement, and consolidate billing into a single, clear invoice for the patient. A diffracted system where separate invoices and explanations of benefits (EOB) are sent to the patient by each provider and then again by the

[1] Tseng, P., Kaplan, R. S., Barak, R. D., Shah, M. A., & Schulman, K. A. (2018). Administrative Costs Associated with Physician Billing and Insurance-Related Activities at an Academic Health Care System. 319(7).

insurer makes no sense. We urge the Committee to examine this fundamental question and evaluate methods that would simplify the process for patients, providers, and insurers alike.

This issue could be resolved if Congress were to realign billing and make health plans responsible for all patient billing, including co-pays, deductibles, and out of network bills. All providers, whether in or out of network, could be required to bill through the insurer, which could negotiate rates, consolidate bills (whether in or out of network), and communicate with the customer. To the extent that providers were no longer responsible for the costs of billing or bad debts, they would be required to pass their savings back to health plans through lower charges.

Adventist HealthCare believes such a realignment makes the billing process more transparent for everyone (something universally agreed to among patients, providers, and health plans) and allows providers of care and health plans to focus on their respective areas of expertise. Insurers would be empowered to focus on their core excellence – managing risk and their financial relationships with their customers. Providers would be empowered to focus on their primary function – patient health and providing care. As a result, the proposed realignment would:

- Make the billing process more efficient and transparent for patients. Patients would receive one comprehensive bill, not multiple bills from numerous providers.
- Enable insurers to negotiate lower provider rates. Providers would pass back savings from reduced billing expense. Government bad debt payments could be shifted from providers to health plans to offset insurer bad debts;
- Allow true "price comparison tools" by enabling plans to provide *total* out-of-pocket cost estimates *before* services are provided;
- Shift responsibility for consolidated billing to health plans which are already experts at tracking the complex array of billing variables, leaving providers to focus on care.

The attached Executive Summary to the Dobson Davanzo paper discusses the re-alignment in greater detail. For a copy of the complete white paper, please contact Jeannine M. Bender at Jbender@kslaw.com ; 202-626-9220.

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Adventist HealthCare applauds your commitment to protecting patients from financial disaster and undue anxiety at a time when their full focus should be on healing and recovery. Thank you for the opportunity to submit these comments. Please feel free to contact Adventist HealthCare directly by sending any questions or follow-up you may have to Andrew Nicklas, Director of Government Relations at ANicklas@adventisthealthcare.com.

Executive Summary

Healthcare billing is confusing. Intersecting and overlapping relationships between patients, providers, and insurers frustrate consumers and make it nearly impossible to anticipate out-of-pocket medical costs. Additionally, administrative costs from inefficiencies in billing and collections are often overlooked as cost drivers in the healthcare financing environment. These inefficiencies are confusing and potentially financially harmful to consumers. This white paper examines the healthcare billing process and proposes a realignment of the billing and collection of deductibles, coinsurance and copayments **from** healthcare providers **to** health insurance plans.

As medical care has become increasingly specialized, a greater number of providers[1] can contribute to an individual patient's care, whether in today's largely fee-for-service system or in a managed care environment. A relatively simple encounter can result in multiple bills from primary care and specialty providers, labs and other diagnostic services. A hospital stay can result in numerous bills from a variety of physicians, contracted providers, and suppliers.

Simultaneously as healthcare spending grows faster than the overall economy, health plans have responded to financial and other pressures by redesigning coverage. An increasingly common tool used by plans is an increased amount of consumer cost-sharing[2]. Increased consumer cost-sharing is most evidenced by the emergence of high-deductible health plans[3] (HDHPs), in which consumers are responsible for 100 percent of medical costs until deductibles are reached. Increased cost-sharing and HDHPs can negatively impact all stakeholders in the health care environment, as follows:

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[1] For the purposes of this framework, a provider is defined as any individual, institution, or agency that provides medical services to consumers. This does not include dental services.

[2] Medical service expenses that are not reimbursed by the health plan and are the responsibility of the consumer; this include patient out-pocket-costs pertaining to deductibles, coinsurance, and copayments for covered services, and at times may include balance billing.

[3] The Internal Revenue Service (IRS) defines High Deductible Health Plans (HDHPs) as any plan with a deductible of at least $1,350 for an individual or $2,700 for a family, refer to https://www.healthcare.gov/glossary/high-deductible-health-plan/

- Consumers can experience financial crises, in addition to medical crises, through significant debt and bankruptcy, especially from payments associated with unanticipated medical services;
- Providers can experience financial pressures resulting from increased charity care and bad debt from patients who cannot afford to pay their share of medical bills under an HDHP as well as increased administrative costs associated with insurance activities, follow-up billing/collections effort, and lags in payment;
- Health plans can experience pressures to reduce premiums from consumers, increase payments from providers, and competitive pressures to offer coverage with high cost-sharing components.

These increasing pressures are leading to a healthcare system that is becoming financially unsustainable. A vicious cycle has resulted in which health plans increase cost sharing requirements to reduce insurance premiums, consumers are unable to afford cost-sharing requirements and are unaware of how to lower their costs, and providers incur more responsibility for billing and collections and, ultimately, more bad debt.

The resulting misalignment in the healthcare system is especially evident in increasing levels of financial exposure of individual consumers who require significant medical services. This financial exposure has also had the impact of further complicating the billing processes for providers. With HDHPs, it is more difficult for providers to determine the amount of deductible the patient has met in order to bill the correct amount. Some physicians have had to hire additional staff to attend to their increasingly involved billing activities, others have simply opted to become part of bigger health systems to avoid patient billing[4].

Adventist HealthCare commissioned Dobson DaVanzo & Associates, LLC to explore a policy reform approach that would protect consumers and improve efficiencies for all stakeholders by realigning the financial structure of current deductibles and co-payments. The structure proposed by Adventist centralizes health plans[5] as the single point-of-contact for billing and collection of both health plan premiums and all other patient out-of-pocket costs, thus allowing providers to focus on the provision of clinical services. The resulting Consumer Protection Realignment (CPR) structure would simplify the consumer experience by streamlining billing processes, while reducing provider costs and bad debt.

[4] Dodge, Blake. (2018, November). Doctors Are Fed Up with Being Turned into Debt Collectors. Retrieved form Bloomberg. https://www.bloomberg.com/news/articles/2018-11-15/doctors-are-fed-up-with-being-turned-into-debt-collectors?utm_campaign=news&utm_medium=bd&utm_source=applenews

[5] For the purpose of this framework, the term health plan refers to employer-sponsored health insurance plans, Employee Retirement Income Security Act of 1979 (ERISA) self-funded plans, individual health insurance plans, as well as federal health insurance programs such as the Affordable Care Act (ACA) Health Insurance Marketplaces, Medicare Advantage Organizations (MAOs), Medicare Cost Plans, Medicaid Managed Care Organizations (MCOs), the Children's Health Insurance Program (CHIP) and regular Medicare and Medicaid paid on a Fee-for-Service (FFS) basis.

These cost reductions could be passed on to health plans as lower payment rates. The purpose of this white paper is to develop a broader conceptual framework of such a policy.

At its core, CPR would enable providers to focus on patient relationships and clinical issues. CPR would enable health plans to focus on financial issues. This would protect consumers by:

1) Making the billing process more efficient for patients (a consolidated bill issued by the health plan, not numerous providers' individual bills);

2) Enabling price transparency[6] through comprehensive out-of-pocket cost estimates provided by the health plans before services are provided— making the healthcare system more competitive; and

3) Reducing the practice of "surprise" balance billing[7] through best efforts to protect the consumer from such billing situations and calling for a federal solution aligned with state activities.

This structural policy reform, while innovative, is not intended to "revolutionize" healthcare. Instead, it proposes to realign existing healthcare infrastructure based on the natural nexus between patients, providers and insurers in a manner that will promote transparency and better understanding for consumers. Its aim is to better protect patients from financial loss while providing a fairer, better informed "playing field" for all stakeholders. In the near-term CPR would be budget neutral to current expenditure levels.

An anticipated outcome of CPR is reduced provider patient billing and collection efforts, achieved by aligning this administrative responsibility with the fiduciary responsibility of health plans. Providers would still need to bill health plans for their services, but they would no longer bill insured patients for their out-of-pocket amounts, generally copayments, coinsurance and deductibles. Health plans, being the "keepers" of all of the financial data would in a better position to improve the billing experience for consumers.

Anticipated savings from the elimination of system inefficiencies related to insured patient billing and the risk of bad debt and charity care costs are expected to be passed on to health plans in the form of negotiated healthcare service rate reductions. In addition, the CPR would call for the adjustment of Medicare and Medicaid Disproportionate Hospital (DSH) funds to reflect reduced insured patient bad debt. The resulting funds would be rechanneled to compensate health plans via a reinsurance program designed to abate the potential negative financial implications of absorbing patient bad debt and providing charity care.

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[6] Per the Healthcare Financial Management Association (HMFA), price transparency defined as "readily available information on the price of healthcare services that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value." Refer to Report from the HFMA Price Transparency Task Force, file:///C:/Users/larzaluz/Downloads/Price%20Transparency%20Report%20(1).pdf

[7] Occurs when a provider is out-of-network and the health plans pay smaller portions of the bill, while the patient remains liable for the balance out-of-network charges.

Further, CPR would, in the near-term, likely increase market incentives for health plans to offer coverage with lower levels of cost-sharing and decrease unnecessary healthcare utilization to mitigate the financial risk of bad debt. In the long-run, CPR may result in greater predictability in healthcare spending and utilization through bundled payments and other innovative financing approaches designed to reduce overall system cost and administrative complexity.

It is important to note that this proposal could result in several collateral consequences that would need to be carefully considered. For example, CPR could alter the balance of power between health plans and providers, such that health plans could have more leverage in the system. In addition, the use of out-of-pocket cost estimates for consumer decision making may be difficult to implement, given the many variables that reduce price transparency. Also, a quantitative analysis of likely provider savings would need to be completed to assess potential impact and, hence, the functionality of CPR.

Finally, the potential moral hazard arising from consumers not having to pay out-of-pocket costs to providers at the point-of-service would need to be addressed. We expect public debate by stakeholder groups on the operational feasibility and legislative possibilities of CPR. Indeed, an objective of this white paper is to encourage such debate. However, the many potentially significant benefits for patients that result from the realignment of stakeholder responsibility for medical billing warrants such a debate. ***Figure 1***, on the next page, summarizes CPR. The following section expands on the issues that CPR is meant to ameliorate, followed by a more detailed description of the CPR and its implications for patients, providers, and health plans. The paper then presents a discussion of long-term considerations and a conclusion.

Figure 1. Consumer Protection Realignment (CPR) System Overview